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REQUEST AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

Today's Date: ___/___/_____

Patient Name:
Birthdate:
Address (address, city, state, zip code):
Phone:
E-mail Address:
I authorize ____________ to use or disclose the following health information during the term of this Authorization. (Check all that apply.) __ Test Results __ Complete Medical Record __ Billing Records
I authorize disclosure of the above information for the following dates of treatment. __ All Dates __ Specific Date: ___________________
Health Information Format: __ Paper Copy __ Electronic Copy
Delivery Method: __ US Mail __ Electronic Mail __ Fax: ____________________
Purpose: __ At the request of the patient. __ Other ___________________
Send To:

Name: ____________________ Address: ____
E-mail: ____________________ Phone: ____________________

SPECIFIC CONSENT:

By checking any of these boxes, I am specifically authorizing ________ to use and/or disclose the category of confidential information indicated:

__ Information about HIV/AIDS testing or treatment (including the fact that an HIV test was ordered or performed, regardless of the result of the test)
__ Information about Communicable Diseases
__ Information about Venereal Diseases

This authorization will remain in effect until the purpose is fulfilled. Without my express revocation, the authorization will automatically expire 1) upon satisfaction of the need for disclosure or 2) on _____/_____/_______,. I understand that I may revoke this Authorization in writing at any time by notifying ______________. I understand that changing my mind will not affect my treatment. The revocation will not apply to the extent that ______________ has already taken action where it relied on my permission. Furthermore, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and, if so, it may no longer be protected by a federal confidentiality law.

Signature of Patient or Personal Representative: _______________________________________

Date: ___________________

Name of Personal Representative: _________________________ Relationship to Patient: _________________

(I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.)

Please return this form to :

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FOR OFFICE USE ONLY: Date Released: _________________ Released By: __________________